

ENROLLMENT FORM

DOD NAF HBP RETIREE HEALTH PLAN

2001

Retiree Name:	<div style="border: 1px solid black; height: 20px;"></div>		
	Last Name	First Name	M.I.
Date of Birth	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>	Social Security #	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>
Date of Separation	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>	Current Mailing Address	
Current Coverage:	Self Only Surviving Spouse Only Family 1 yr. disability medical Free medical age 62-65	<div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100%; height: 20px;"></div> <div style="border: 1px solid black; width: 100%; height: 20px;"></div> <div style="border: 1px solid black; width: 100%; height: 20px;"></div> <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
		Telephone Number (include area code)	

DOD NAF HBP RETIREE HEALTH ELECTION

<p><u>I elect the DOD HBP Retiree Medical Plan.</u></p> <div style="margin-top: 20px;"> <input type="checkbox"/> Single Medical, With Dental (\$87.56 per month) </div> <div style="margin-top: 20px;"> <input type="checkbox"/> Family Medical, With Dental (\$203.98 per month) </div>	<p>Check the box below that applies:</p> <p><i>All features mirror the DOD NAF HBP, POS PPO or Traditional plan which applies where you live. This plan INCLUDES dental coverage.</i></p> <p><i>For retirees over age 65 you are automatically enrolled in traditional choice plan and <u>must</u> enroll in Medicare part A & B to receive maximum benefits.</i></p>
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Dependent Information: Complete ONLY if you are applying for family coverage

Spouse Name (Last, First, MI)	SSN	DOB
Child Name (Last, First, MI)	SSN	DOB
Child Name (Last, First, MI)	SSN	DOB

Submit payment by check for premiums due from date of term thru end of month and for the month following this enrollment form

MAKE CHECK PAYABLE TO : ARMY MEDICAL LIFE FUND AND MAIL TO: P.O. BOX 107, ARLINGTON, VA 22210-0107

By my signature I acknowledge that premiums for the coverage elected herein are subject to change from time to time as determined by the Plan Administrator, and that this plan may be terminated or modified in any way at the discretion of the Plan Administrator. I further understand that if I am eligible for Medicare benefits, I **MUST** enroll in Medicare part A & B as my primary payor immediately upon becoming eligible for Medicare (at age 65 or upon Medicare recognized disability) and will enroll in Medicare immediately upon reaching eligible status). Premiums will be automatically deducted from your annuity check beginning next month.

Signature of Retiree (Spouse must sign if retiree is deceased)	Date
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BILLING START DATE:

Retiree Health Pro-rate Table (CY) 2001

SINGLE RETIREE MEDICAL WITH DENTAL \$87.56 MONTHLY
FAMILY RETIREE MEDICAL WITH DENTAL 203.98 MONTHLY

Months with 31 Days Jan, Mar, May, July, Aug, Oct and Dec			Months with 30 days April, June, September and November			Month with 28 days February (no leap year)		
	SINGLE	FAMILY		SINGLE	FAMILY		SINGLE	FAMILY
1	\$87.56	\$203.98		\$87.56	\$203.98		\$87.56	\$203.98
2	\$84.74	\$197.40		\$84.64	\$197.18		\$84.43	\$196.70
3	\$81.91	\$190.82		\$81.72	\$190.38		\$81.31	\$189.41
4	\$79.09	\$184.24		\$78.80	\$183.58		\$78.18	\$182.13
5	\$76.26	\$177.66		\$75.89	\$176.78		\$75.05	\$174.84
6	\$73.44	\$171.08		\$72.97	\$169.98		\$71.92	\$167.56
7	\$70.61	\$164.50		\$70.05	\$163.18		\$68.80	\$160.27
8	\$67.79	\$157.92		\$67.13	\$156.38		\$65.67	\$152.99
9	\$64.96	\$151.34		\$64.21	\$149.59		\$62.54	\$145.70
10	\$62.14	\$144.76		\$61.29	\$84.00		\$59.42	\$138.42
11	\$59.31	\$138.18		\$58.37	\$135.99		\$56.29	\$131.13
12	\$56.49	\$131.60		\$55.45	\$129.19		\$53.16	\$123.85
13	\$53.67	\$125.02		\$52.54	\$122.39		\$50.03	\$116.56
14	\$50.84	\$118.44		\$49.62	\$115.59		\$46.91	\$109.28
15	\$48.02	\$111.86		\$46.70	\$108.79		\$43.78	\$101.99
16	\$45.19	\$105.28		\$43.78	\$101.99		\$40.65	\$94.71
17	\$42.37	\$98.70		\$40.86	\$95.19		\$37.53	\$87.42
18	\$39.54	\$92.12		\$37.94	\$88.39		\$34.40	\$80.14
19	\$36.72	\$85.54		\$35.02	\$81.59		\$31.27	\$72.85
20	\$33.89	\$78.96		\$32.11	\$74.79		\$28.14	\$65.57
21	\$31.07	\$72.38		\$29.19	\$67.99		\$25.02	\$58.28
22	\$28.25	\$65.80		\$26.27	\$61.19		\$21.89	\$51.00
23	\$25.42	\$59.22		\$23.35	\$54.39		\$18.76	\$6.00
24	\$22.60	\$52.64		\$20.43	\$47.60		\$15.64	\$36.43
25	\$19.77	\$46.06		\$17.51	\$40.80		\$12.51	\$29.14
26	\$16.95	\$8.91		\$14.59	\$34.00		\$9.38	\$21.86
27	\$14.12	\$32.90		\$11.67	\$27.20		\$6.25	\$14.57
28	\$11.30	\$26.32		\$8.76	\$20.40		\$3.13	\$7.29
29	\$8.47	\$19.74		\$5.84	\$13.60			
30	\$5.65	\$13.16		\$2.92	\$6.80			
31	\$2.82	\$6.58						

* USE THE DAY FOLLOWING TERMINATION FOR THE PRO-RATED PREMIUM AMOUNT DUE FOR THE MONTH OF EMPLOYMENT TERMINATION (I.E. IF YOU TERMINATE ON OCTOBER 23RD, YOU OWE \$22.60 FOR RETIREE COVERAGE WITH MEDICARE OR IF YOUR EMPLOYMENT TERMINATION DATE IS APRIL 10TH, THE SAME COVERAGE WOULD COST \$58.37) THE DAYS OF THE MONTH ARE LISTED DOWN THE SIDE OF THE CHART.

PREMIUM WORKSHEET

	Single	Family
Date of Termination	<input type="text"/>	<input type="text"/>
Determine number of days remaining in Termination month	<input type="text"/>	<input type="text"/>
Enter amount from Chart Above	<input type="text"/>	<input type="text"/>
Current Month Premium (if current month is Term Month Enter Zero)	<input type="text"/>	<input type="text"/>
Next Month Premium	<input type="text"/>	<input type="text"/>
Total	<input type="text"/>	<input type="text"/>